

Claim # _____
For Office Use Only

**WYOMING OFFICE OF THE ATTORNEY GENERAL
DIVISION OF VICTIM SERVICES
CRIME VICTIM COMPENSATION PROGRAM**



122 W. 25th, Herschler Bldg., 1st Floor West, Cheyenne, WY 82002
Phone (307) 777-7200 Victim Toll-Free (888) 996-8816
Fax (307)777-6683

E-mail: victimservices@state.wy.us
Website: victimservices.wyoming.gov

AN INCOMPLETE APPLICATION WILL BE RETURNED

VICTIM INFORMATION		Victim Name			
Mailing Address			City		State Zip Code
Home/Daytime Phone # ()		Work/Message Phone # ()		E-mail	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth / /	Social Security #		
For Federal Statistical Purposes Only					
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Multi-Racial					
Disabled (prior to crime) <input type="checkbox"/> Yes <input type="checkbox"/> No			Disabled (as a result of crime) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Wyoming Resident <input type="checkbox"/> Yes <input type="checkbox"/> No			Federal Crime <input type="checkbox"/> Yes <input type="checkbox"/> No (See instructions for explanation)		
CLAIMANT INFORMATION		Section must be completed if the victim is: <input type="checkbox"/> deceased <input type="checkbox"/> incompetent <input type="checkbox"/> minor		Relationship to Victim	
Claimant Name			Social Security #		Date of Birth / /
Mailing Address			City		State Zip Code
Home/Daytime Phone # ()		Work /Message Phone# ()		E-Mail	
CRIME INFORMATION		*ATTACH LAW ENFORCEMENT REPORT & CERTIFICATION *THIS SECTION MUST BE COMPLETED OR APPLICATION WILL BE RETURNED			
Crime Date / /		Crime Reported / /		Case #	
Type of Crime: <input type="checkbox"/> Assault <input type="checkbox"/> Child Physical Abuse <input type="checkbox"/> Child Sexual Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> DWI <input type="checkbox"/> Homicide <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Stalking <input type="checkbox"/> Other explain _____					
Crime Reported to: <input type="checkbox"/> Police <input type="checkbox"/> Sheriff <input type="checkbox"/> Highway Patrol <input type="checkbox"/> FBI <input type="checkbox"/> BIA <input type="checkbox"/> Nat'l Park <input type="checkbox"/> Other _____					Responding Officer or Detective:

Location of Crime	City	County	State
Has arrest been made? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Charged in Court? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Which Court? <input type="checkbox"/> Municipal <input type="checkbox"/> Circuit <input type="checkbox"/> District <input type="checkbox"/> Tribal <input type="checkbox"/> Federal <input type="checkbox"/> Unknown			
Outcome of case? <input type="checkbox"/> Under investigation <input type="checkbox"/> Other <input type="checkbox"/> Prosecution declined <input type="checkbox"/> Conviction <input type="checkbox"/> Unknown		Has Restitution been ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Restitution Amount \$ Which Court?
OFFENDER INFORMATION	Name of Offender (s)		
Offender(s) Date of Birth:	Social Security Number	Offender(s) Address	
Name of Offender(s) Employer	Name of Offender(s) Address	Offender(s) Employer's Phone #:	
Does Offender(s) have a Checking Account? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Name of Institution _____ Account #: _____			
Does Offender(s) have a Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Name of Institution _____ Account #: _____			
CIVIL SUIT	<i>The Division of Victim Services must be notified if a civil suit is filed.</i>		
Do you plan to file a civil suit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time			
If so, who is your attorney? Name _____			
Address _____			
Phone _____		Outcome of Civil Suit	
REQUESTED BENEFITS	Check benefits requested.		
<input type="checkbox"/> Medical/Dental/Counseling <input type="checkbox"/> Funeral/Burial Expenses <input type="checkbox"/> Other Economic Expenses <input type="checkbox"/> Catastrophic Injury <input type="checkbox"/> Loss of Earnings <input type="checkbox"/> Loss of Support			
MEDICAL/DENTAL/ COUNSELING EXPENSES/Prescriptions	Attach all itemized bills related to crime. Attach Insurance Explanation of Benefits.		
*Name of Provider (Must Include address/phone number) Attach additional sheets if needed			Amount
			\$
			\$
			\$
			\$

**INSURANCE/
OTHER COLLATERAL SOURCES**

All bills must be submitted to your insurance carrier or other sources before applying.

Was the victim covered by any health insurance or assistance plan at the time of the crime? Yes No

Carrier/Benefit Plan (Check all that apply)
Must Include Company Name/Policy number/Policyholder/Address/Phone

Health Insurance

Medicare/Medicaid/Title 19

Workers'/Unemployment Comp

Veteran's Administration/Military Insurance

Public Assistance/Welfare/Food Stamps

Accident/Life Insurance
Must be included if victim is deceased

Social Security/SSI/SSDI

Indian Health Services

Victim Auto Insurance
Must be Included if Auto Related Crime

Offender Auto Insurance
Must be Included if Auto Related Crime

Home Owner Insurance)

Other

FUNERAL/BURIAL EXPENSES

**Attach itemized copies of funeral/burial bills.
(\$5000.00 Maximum Benefit)**

Name of Funeral Home _____ Address/Phone number: _____

If the victim/deceased had life insurance, please provide the name of company. _____

Other Expenses _____

OTHER ECONOMIC EXPENSES Attach receipts/bills/estimates for replacement items or clean-up costs. Must file insurance first. Check all that apply.

- Personal Articles Taken As Evidence (\$500 max.) Identify Articles/Estimate Value
- Homemaker Replacement (Name/Phone # of service provider)
- Crime Scene Clean-up (\$500 max.) Hotel
(If there is homeowner or rental insurance, this must be filed first)
- Transportation/Mileage Relocation Expenses: Other Losses:

CATASTROPHIC INJURY Partial or permanent disability of limbs, sight, hearing, or speech as a direct result of crime. Include receipts/estimates of home/vehicle improvements or devices. (\$10,000.00 maximum benefit)

Type of disability _____ Name of doctor to verify disability _____
Address _____ Phone _____

LOSS OF EARNINGS Complete if you lost time at work due to a crime. If the victim is self-employed, include a copy of the most recent federal income tax report.
Victim must be employed at time of crime

Was the victim employed at the time of the crime? Yes No
 Did the victim miss any time from work as a result of the crime? Yes No
 Has victim returned to work? Yes No
 Dates absent from work due to crime: / / Until / / Total Hours Missed:

Employer's Name _____ Contact Person _____ Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

Did you receive any of the following due to injury/crime? Sources must be exhausted first.
 Sick Leave Vacation Pay Worker's Compensation Disability Union Plan Other

LOSS OF SUPPORT This section must be completed when there is loss of support in the event of the death of the victim or the victim was incapacitated and was a source of support for the family and is no longer able to contribute.
Must be employed at time of crime

Was the deceased/incapacitated victim employed at the time of the crime? Yes No

Deceased/Incapacitated Victim's Employer Name _____ Contact Person _____ Phone # _____

Employer Mailing Address _____ City _____ State _____ Zip _____

REFERRAL SOURCE This section to be filled out by Victim Advocate filling out this application.

Name of Advocate: _____ Agency Name: _____ Address: _____
Phone Number: _____ E-mail address: _____

- Mark all services victim was referred to or currently working with:
- Victim/Witness Program Hospital/Doctor Court System Brochure/Poster
 - Family Violence Shelter Funeral Home/Coroner Prosecutor Relative/Friend
 - Law Enforcement Counselor/Therapist Probation Other
 - Attorney Public Assistance News/Media

Before sending this application, make sure to:
 Sign and date the following authorization page Attach summary of crime and injuries
 Attach copies of bills, estimates, and receipts Complete all appropriate sections of the application

STATEMENT OF UNDERSTANDING

I understand after receiving this application, the Division of Victim Services Compensation Program staff will investigate the accuracy and truthfulness of the information given on this form and any other necessary matters regarding this claim, and I consent to such investigation.

I understand the Division may release records in their control, and seek records from other agencies, in connection with my claim relating to any compensation awarded to me or paid on my behalf. This includes, but is not limited to, the prosecuting attorney's office, probation and parole, and other parts of the federal or state court system, as they seek restitution from the defendant.

I understand I am required, and I hereby agree, to notify the Division if I hire an attorney to represent me in a lawsuit related to the crime that led me to file this application. I also agree to notify the Division if the offender offers to reimburse me for my losses.

I understand the Division is the payer of last resort. It is my responsibility to make sure all other forms of payment have been exhausted. If other forms of payment become available during the processing of the application, I will notify the Division. Otherwise, failure to provide this information may jeopardize my eligibility for compensation.

I understand based on W.S. 14-3-205, the Division of Victim Services is required to report suspected child abuse to the proper authorities.

ASSIGNMENT OF BENEFITS (DIRECT PAYMENT TO SERVICE PROVIDERS)

From any award made by the Division of Victim Services Compensation Program, I give permission to the Division to pay any applicable unpaid bills directly to the appropriate parties.

AGREEMENT OF VICTIM/CLAIMANT

I hereby agree to repay the Division of Victim Services the amount of the award, or as much as recovered, if I recover payment from the person or persons responsible for the injuries for which I am seeking compensation, as outlined by Wyoming Statute 1-40-112(a). I understand this includes repaying the Division if I recover any amount from the offender, his/her insurance company, his/her employer's insurance company, or any other entity who is paying on behalf of the offender for the damages sustained by me due to the crime described in this application.

AUTHORIZATION TO OBTAIN RECORDS, RELEASE OF INFORMATION, AND TO CONDUCT AN INVESTIGATION TO REVIEW AND EVALUATE MY CLAIM

I give permission to any hospital, doctor, federal, state, or local law enforcement agency, insurance agency/company, employer, social service agency, or any federal, state or local government agency, including the Social Security Administration, and privately retained attorneys to release all records, to answer any questions, and to provide any information to assist the Division in processing this compensation claim. I also give my consent to the Division to exercise its own discretion in releasing or withholding information regarding my crime-related losses to any person or entity responsible for submitting restitution requests to the court. I understand this information will be confined to an itemization of my crime-related monetary losses, in so far as the Division is aware of them. I agree the Division may release information regardless of whether I have received a compensation award. I understand this information will be released only for the purpose of obtaining an order of restitution from the defendant(s) or for determining eligibility for compensation. Furthermore, I understand this release form which I have signed in no way obligates the Division to release information, to gather and present more information than it already possesses, to pursue an order of restitution on my behalf or to pursue collection of restitution on my behalf. I understand the issue of restitution collection rests solely with the court system and not with the Division.

I also understand the limitations of this agreement in no way limits the Division's ability to pursue its own revenue recovery to the extent it provides me with compensation benefits.

This authorization is valid for two years from the date given below. A photo copy of this authorization is as effective and valid as the original.

I certify under penalty of perjury and subject to the provisions of W.S. § 1-40-102 through 119 and its penalties, the foregoing claim is true and a just record of expenses incurred by me as a result of the crime against me. I further certify under penalty of perjury I have read and understand the statements above including the "Statement of Understanding" and "Agreement of Victim/Claimant" and I agree to them. **(Should be signed by victim 18 years or older, an emancipated minor, or their parent or guardian.)**

Victim Name

Claimant Name

Victim Social Security Number

Claimant Social Security Number

Street Address or Box Number

Street Address or Box Number

City, State, Zip

City, State, Zip

Signature of Victim or Claimant **18 years of age or older**

Date Signed

**Return to: Division of Victim Services, 122 W. 25th, Herschler Bldg. 1st Floor West, Cheyenne, WY 82002.
For assistance with completing this application, call toll- free at 1-888-996-8816 or 1-307-777-7200.
Revised 10/09**

THIS PAGE MUST BE COMPLETED, SIGNED AND DATED!!

RETURN TO:
DIVISION OF VICTIM SERVICES
122 W 25TH, 1ST FLOOR WEST
CHEYENNE, WY 82002
(307) 777-7200
FAX (307) 777-6683

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Attorney General Office Use Only

STATE OF WYOMING

**REQUEST FOR TAXPAYER
IDENTIFICATION NUMBER & CERTIFICATION**

PLEASE PRINT OR TYPE: Forms that are illegible or incomplete will not be processed.

PURPOSE OF THE FORM: The State of Wyoming is required to file an information return with the IRS and must have your correct Taxpayer Identification Number (TIN) to report.

IRS regulations provide the following: If you fail to furnish your correct TIN to a requestor, you may be subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. If you make a false statement with no reasonable basis that results in no backup withholding, you may be subject to a \$500 penalty. If you willfully falsify certifications or affirmations you may be subject to criminal penalties including fines and/or imprisonment.

Individual/Sole Proprietor

NUMBER: _____
(SSN)

NAME: _____
(Official Tax Reporting Name)

MAILING ADDRESS: (Number, Street, and Apt. or PO Box): _____

CITY

STATE

ZIP

PHONE NUMBER: (Include area code) _____

FAX: (Include area code) _____

I CERTIFY UNDER PENALTY OF PERJURY THAT:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me),
- *2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I certify I am a U.S. Citizen

* You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

SIGNATURE: _____

DATE: _____

**IN ORDER TO RECEIVE APPROVED BENEFITS,
THIS FORM MUST BE COMPLETED, SIGNED AND DATED!!**